Diastasis Recti with Dr. Heather Jeffcoat

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IN THIS EPISODE

Pelvic health physical therapist Dr. Heather Jeffcoat joins Dr. Elliot Berlin, DC for a whole-person tour of the pelvic floor — and a deep dive into the abdominal separation so many people worry about during and after pregnancy. Born and raised in Los Angeles, Heather traces her path from UC San Diego to her doctorate at Duke, where pelvic health was woven through the curriculum from an orthopedic lens, and explains why she never treats a body part in isolation: pelvic pain and dysfunction are often driven from somewhere else entirely. She lays out what the pelvic floor actually is and the four jobs it does, and the many ways things can go wrong — pregnancy itself, delivery, straining, even the way you breathe and exercise. Then the conversation turns to diastasis recti: what that bulge or dome along the midline really is, how it can look different during pregnancy than postpartum, and just how common some degree of separation is by late pregnancy. Heather explains how she assesses it — why both the width of the gap and the depth and tension beneath her fingers matter — what can worsen it, whether support garments help, and why the goal is not simply closing the gap to a finger's width. She makes the case for starting therapy far earlier than the traditional six-week wait, walks through what treatment actually involves (abdominal retraining, breath work, and pelvic floor assessment), names the exercises and habits to avoid, and answers the question she hears constantly: will the muscles ever get back to normal? And if exercise and therapy are not enough, what does the surgical option really restore — and what does it not?

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DR. ELLIOT BERLIN, DC: Really informed pregnancy and parenting podcast. I'm your host. Dr. Elliott berlin in this episode We are going to explore diastasis recti Separation of abdominal muscles at the midline that sometimes happens during pregnancy and childbirth My guest today is a distinguished expert in the field of pelvic health physical therapy And she's the author of sex without pain a self-treatment guide to the sex life you deserve She's a practicing pelvic health physical therapist in los angeles and she is the president-elect Of the academy of pelvic health physical therapy. Dr. Heather jefkoat. Welcome to the podcast

DR. HEATHER JEFFCOAT: Thank you. Dr. Berlin. Thank you so much for having me here I am honored first of all your attention to detail and your ever Ongoing quest for knowledge and improving and learning how we can help people in other ways is inspiring And then also I have the incredible honor of co-treating some patients with you And it's an incredible honor to be a member of your team or the patient's team to work with you

DR. ELLIOT BERLIN, DC: Likewise, thank you. All right, let's start at the beginning We're going to be talking in general about pelvic health physical therapy or pelvic health therapy And then in the middle segment we'll get into diastasis recti Which is something that people are nervous about all the time during after pregnancy and uh, not sure what it is Not sure how to potentially prevent it or even diagnose it And if you have it what can be done about it? We'll talk about that in the middle segment and then we could also get into other things that pelvic health therapy treats But let's start at the beginning where you're from and how'd you get interested in physical therapy?

DR. HEATHER JEFFCOAT: Well, I am actually born and raised in los angeles I feel like i'm one of the few people maybe that can say that But I went to undergrad at uc san diego and then I moved out to north carolina and got my doctor of physical therapy from duke university And you know at the time when I went there it was very unique because they had a lot of Women's health and pelvic health content like woven into our curriculum And it was really there that I saw that pelvic health was approached from like an orthopedic lens It wasn't viewed as a like isolated area of dysfunction It was really taking into account the whole person And I just developed a passion through that I did not go to pt school thinking I would do this

DR. HEATHER JEFFCOAT: But I learned about it there and I was so thankful and when I first graduated I did Like some sports medicine initially, but then within six months I started doing more women's health and pelvic health And i've been doing sort of like orthopedic sports medicine and a lot of abdominal and pelvic health ever since

DR. ELLIOT BERLIN, DC: So while around people can come to you for lots of different things

DR. HEATHER JEFFCOAT: Exactly, and I really look at people like I said as their whole person not just as a part because These problems are really most of the time driven from other areas of their body So for example, someone might have a pelvic pain or a pelvic floor dysfunction that could be exacerbated by their hip or lumbar dysfunction So you really have to treat someone as a whole person to get them to their optimal outcome

DR. ELLIOT BERLIN, DC: I mean more than anything. I'm like wondering what it's like for an angelino in north carolina

DR. HEATHER JEFFCOAT: What it's like? Yeah What was that like for you? Oh, in North Carolina? Um, well, so here's the thing, Duke is a lot of transplants. So there were mostly people I would say from the northeast. And you know, I definitely came across like many people that were southern. But my graduate program was a mix of people from the south and people from the northeast and a couple people from California. So I think it's like a little bit sheltered when you're in an academic setting. But yes, very quickly when you're in Durham, North Carolina, you go like 10 minutes any direction and they can get really rural really quick, which is different than Los Angeles. Very different. And yeah, it's

like turn

DR. HEATHER JEFFCOAT: left at the Bojangles like chicken, it's not like there's no street names given in direction. So there's definitely a learning curve there. All right. Now that we know a little bit more

DR. ELLIOT BERLIN, DC: about you, let's learn a little bit more about pelvic floor health, starting with

DR. HEATHER JEFFCOAT: what is the pelvic floor? So basically the pelvic floor is a group of muscles at the base of the pelvis. And those muscles surround the openings of your pelvic floor, the urethra, the vagina and the anus. And it has four very important functions. They provide support for your organs. They provide postural support in working with your deep abdominal muscle layer called your transverse abdominus to basically form like an internal corset and lower pelvic support. They provide a sphincteric function so that you don't pee or poop yourself. And they provide a sexual function. So the pelvic floor is involved in achieving and maintaining and involved in the intensity of orgasms. Sounds like some important things

DR. ELLIOT BERLIN, DC: all things you want to be healthy. How do things go wrong in the pelvic floor?

DR. HEATHER JEFFCOAT: So many, many things can go wrong in the pelvic floor at any time. I think, you know, I think it's hard being a woman. Sometimes our pelvis is anatomically are wider than a male pelvis and they are just more susceptible to injury and dysfunction. They don't have bony support. We rely a lot on our muscles and our ligaments. So just being pregnant regardless of mode of delivery increases your risk of pelvic floor dysfunction. So if you, for example, birth like a nine and a half pound baby and they have what's called like an occiput posterior presentation or sunny side up, you can be at increased risk for third and fourth degree perineal tears, which are called Oasis tears or obstetric anal

DR. HEATHER JEFFCOAT: sphincter injuries. You know, those Oasis tears aren't going to happen if you have a C section, right? Like you're avoiding those, um, as a social graphic and elective C section. However, you still have the weight of the baby on the pelvic floor. That's affected like your ligaments and your muscles. And a lot of my C section mamas have urge urinary incontinence or like urgency frequency issues. So I see that like a little bit more common in like the C section population. For example, if you're relating different types of urgent continents, and then of course, both are at higher risk of prolapse. So, you know, just being pregnant, I think it's really important to be taking care of

DR. HEATHER JEFFCOAT: your body while you're pregnant to minimize the risk of pelvic floor dysfunction, because you know, you can do things to worsen your risk of some of these pelvic floor dysfunctions. It's not just about what's happening during the delivery process. If you're doing like a lot of purple pushing and like a lot of straining, like, yes, that can lead to like diastasis recti issues because of the abdominal strain and further pelvic floor dysfunction. But also just if you're exercising and you don't have good breathing patterns. And if you're doing CrossFit while pregnant, it's fine. But if you're leaking while you're doing CrossFit pregnancy, you already are showing signs of pelvic floor

dysfunction.

DR. HEATHER JEFFCOAT: So you need to learn how to manage those pressures and keep your body safe just to minimize dysfunction during pregnancy. So I guess, you know, pregnancy is one of the big things that can lead to a lot of the pelvic floor dysfunction that you and I both see. But there's other types of pelvic floor dysfunction like chronic pelvic pain, which could be from endometriosis. And then so women tend to have like overactive pelvic floor or vaginismus, vulvodynia, painful bladder syndrome, they all tend to have overactive or short type pelvic floors. So those are other ways women can get pelvic floor dysfunction.

DR. ELLIOT BERLIN, DC: All right. That's some very valuable information. Among those things mentioned, diastasis recti. So let's take a quick break. And when we come back, dive deeper into that topic. We'll be right back with Dr. Heather Jeffcoat. Welcome back to the Informed Pregnancy Podcast. We're talking about pelvic floor health with Dr. Heather Jeffcoat, and specifically we're going to talk about diastasis recti. Let's start at the beginning. What is diastasis recti?

DR. HEATHER JEFFCOAT: So diastasis recti is when you have a bulge or a dome in your abdomen that runs down the middle of your abdomen. So it's basically that dome occurs where the six-pack muscles are meeting and it can really be at any portion between the ribs and the pubic bone, or it could be on the entire length between those two structures. And when we see it, we see it when you're engaging the abs typically, although sometimes if it's severe, we can see it when the abs aren't contracting, just like if they're in a standing position, for example, where there's minimal abdominal contraction. But usually like if they're doing like a sit-up or they're getting out of bed or like up off the treatment table,

DR. HEATHER JEFFCOAT: transitional movements like that, I'll be able to observe that doming or like roundings between the ribs and the pubic bone. Can you see it during pregnancy? Yes, definitely. And during pregnancy, it is always observed as a doming. And I should say postpartum, it can be a doming or it could be a caving in. It can look almost like a valley running between. So it has a somewhat different potential presentation postpartum.

DR. ELLIOT BERLIN, DC: Okay. So this is where the right and left strip of abdominal muscle come apart at the midline. And do you know how common it is during pregnancy?

DR. HEATHER JEFFCOAT: So there is research, although the research does come under criticism, like some research can, but beyond about 35 weeks of pregnancy, I've seen that nearly a hundred percent of women will have some amount of diastasis or separation of that superficial abdominal muscle layer. So it's not a matter of will I have one, it's a matter of when will I have one and, you know, will it resolve on its own postpartum or will I need help getting

DR. ELLIOT BERLIN, DC: things back to midline? Well, as you started to mention, they kind of have different presentations. I mean, it could just be when you're looking up and down, measuring up and down, it could be all the way from the rib cage down to the pubic bone or any portion thereof. So it might be a long separation or it could be a

DR. HEATHER JEFFCOAT: short separation. Yeah, exactly. Sometimes it's just like maybe between the belly button and the ribs, for example. And they are like well together in their lower abs,

but the upper abs, for example, might be separated. And then in addition to that, measuring the degree of it is how white it is.

DR. ELLIOT BERLIN, DC: Right. How do you measure that?

DR. HEATHER JEFFCOAT: So the quick and easy way is by using our fingers and measuring fingers with, but of course that's not a very reproducible way between clinicians because I'm sure you and I put our hands, you know, up against each other, you know, yours and mine. would be a little different. So I don't have this in my office. It's a very expensive machine. It's like 15 or $20,000, but you can use like a clinical ultrasound unit and measure the distance between. But really it's a lot to sort of invest in something that you can still get like a rough idea by just putting your fingers in there. And that will give you an idea of the width, which is one piece of information. But the other piece of information is the depth.

DR. HEATHER JEFFCOAT: So when I'm testing them, I'm testing them doing a crunch and I'm testing like at the belly button above and below the belly button and seeing how far apart each side of those six pack muscles are. And then I get in and I go from above and I press down to see the depth and I have them lift again. And I want to see, do I feel any tension under my fingertips? And that helps me determine if I think they'd be a good candidate for physical therapy related to the diastasis, because if I don't feel anything, there might be a lot of fascial tearing, and I might not be able to help them. Like that might be an instance, for example, where they might need plastic surgery to

DR. HEATHER JEFFCOAT: sew that back together. If there's nothing structurally under there for me to work with, then there's very little I can do. So it really should be a two-part assessment, width and depth.

DR. ELLIOT BERLIN, DC: LARSON During pregnancy, you wonder if there's anything that can be done to help minimize the separation.

DR. HEATHER JEFFCOAT: Yeah, exactly. I mean, if you are straining, so if you have chronic constipation, that's one thing you should get under control. If you're lifting heavy weights, or you're lifting your toddler while you're pregnant, any abdominal wall strain and the lack of ability to manage the pressure through the abdomen, as well as the pelvic floor, can potentially worsen the diastasis. So we want to try to mitigate those pressures as best as possible, so we don't cause further separation. And really, if you're exercising, for example, any exercise that you're doing where you observe the doming between those separated abdominal muscles is probably an exercise that's too challenging for your core to support. So it should be

DR. HEATHER JEFFCOAT: discontinued until you either get a personal trainer or a physical therapist to help guide you through that.

DR. ELLIOT BERLIN, DC: Those are some good pointers. Are there garments that help keep things together?

DR. HEATHER JEFFCOAT: I would not put anything over pregnant belly to compress it, but postpartum definitely. There's different companies that will do custom wraps, which might in theory help. I really like the postpartum support garments by SRC Health. And they're a company out of

Australia. They're high-waisted. They come in short shorts, biker shorts, and full-length leggings. So they just look like your average LA mom uniform, basically. And they provide some good compressive support, not just around the abdominals, but also the pelvic floor. Because even though we're talking about the abdominal muscles, we can't forget how, if we add too much pressure to the abdominal muscles, where is that force going to go?

DR. HEATHER JEFFCOAT: It might possibly go to the pelvic floor, and we don't want to increase risk of prolapse, because we've been focusing so much on compressing around the abdominal muscles.

DR. ELLIOT BERLIN, DC: You said that sometimes these can resolve on their own. What makes someone more or less likely to have it resolve after the pregnancy?

DR. HEATHER JEFFCOAT: That's an amazing question. I actually haven't seen any research that would point to one thing versus another. But I would say from my clinical opinion, one is partly genetics. I just think some people, how did you have a baby six weeks ago? And they're like, I did nothing. I'm like, I need your genes. Another part is if maybe you are just genetically have more lax ligaments, I think you might be more predisposed to things like prolapse and the diastasis. Straining is if you have abdominal muscle straining, that's going to impact that separation. And if you don't have awareness of how to create good tension across the midline, then that could be something that could delay it from recovering as well.

DR. HEATHER JEFFCOAT: And when I say recovering, I don't want to focus like we talked about the width, but it's not just about how wide the gap is. It's about if you can create good tension, because sometimes you might get three fingers width between the abdominal muscle wall, but they have really good tension. And so if it's not impacting them functionally, and they're able to control that doming, then that's a good place for them. It doesn't have to be like one finger's width. So it's not just a goal of how wide is it. It's like how can I get it to function properly so that I don't pee my pants or my back doesn't hurt, for example.

DR. ELLIOT BERLIN, DC: We covered a lot, but I still have more questions about this particular topic. We're going to take a quick break and be right back with Dr. Heather Jeffcoat. Welcome back to the Informed Pregnancy Podcast. We're talking to Dr. Heather Jeff-Cote, and we're talking about diastasis recti. So, for those people who are not lucky enough to have a self-resolving separation, first of all, when do you even start? And second of all, what kinds of things are involved in repairing that?

DR. HEATHER JEFFCOAT: So, I'm a very big advocate, and of course, I'm biased, but I mean, early intervention. I don't believe that women that have a concern about how their body is functioning, I don't think they should wait till they're six weeks post delivery to initiate therapy. So, if patients want to come in with their babies, I mean, I'll see people within the first week so they can get started on their goals. Yeah. You know, why wait? Like, why have six weeks of like, you know, you could get yourself six weeks ahead. So, I think that patients really feel much more supported too, especially because so much has changed in their body. I mean, their center of gravity has changed like so abruptly postpartum.

DR. HEATHER JEFFCOAT: So, you know, getting their muscle from like a neurologic level firing properly again and with good alignment, I think is very empowering to them. And I just do see that they can get back to activities much more quickly than those that wait six weeks or 12 weeks to start therapy. And as far as what it looks like once they've started. So, it's a combination of abdominal muscle retraining. We do breath work. And then oftentimes if I'm able to do a pelvic floor muscle assessment, which would be like at the six week plus mark, at least an internal assessment, then there might be some pelvic floor muscle retraining too, because I wanted to have an idea, are there pelvic

DR. HEATHER JEFFCOAT: floor muscles like in a good, relatively normal state, or are they under active and so that they need to be strengthened? Or are they becoming overactive? Like, are they just getting tight and short, which can help provide stability, which is one reason why our muscles get that way. But it's a stability that can cause dysfunction, like pain or like urgent continents or urgency frequency. So, you know, do they maybe need some like muscle work, like manual therapy if their muscles are overactive prior to initiating a strengthening program? So, those are kind of some of the things. And then, you know, teach them a home program. So, whether it's pelvic floor strengthening, abdominal wall strengthening,

DR. HEATHER JEFFCOAT: you know, scar tissue assessment, I should add actually, as part of that pelvic floor assessment, because if they had a vaginal delivery, we want to make sure that their scar tissue stays nice and mobile so they don't have other issues. They might be coming for their diastasis, but, you know, they didn't realize because they haven't had sex yet that their pelvic floor is tender and that, you know, they might have pain with their partner when they try to resume intercourse. So, when they come in, we just want to make sure that we're addressing their symptoms completely. But, of course, focusing on what their primary complaint might be is like just their diastasis or their abdominal weakness.

DR. HEATHER JEFFCOAT: So, you know, one thing I had mentioned at the beginning was that we do the abdominal muscle retraining. So, we do that in different positions. So, we might start with them lying on their back, making sure that they can not only sort of find a balance between closing the gap, but also getting good tension across the midline so that they're getting good support for their lumbar and their pelvic muscles. And then we might do like hands and knees, seated, standing, doing things in like squat position, lunge position, and advancing to more advanced abdominal strength exercises that might incorporate upper and lower body movement or stabilization type poses just to kind of progress them to

DR. HEATHER JEFFCOAT: a higher level of function without abdominal wall or pelvic floor dysfunction.

DR. ELLIOT BERLIN, DC: Can you elaborate? Because earlier you mentioned breath work. Can you elaborate on what that means?

DR. HEATHER JEFFCOAT: Yeah. So, like when I'm assessing how they're breathing, I'm looking at are their ribs like expanding laterally or out to the side? Are they getting like good movement there? Is it all in the abdominal muscles? Is it really high up in the neck? So, I want to just get a sense of like, where do they tend to breathe at baseline? And then from there, get them to keep that pressure more

evenly spread between like their ribs and their abdominals. So, I don't like it actually when most people do all belly breathing, especially like if they're postpartum, because I just find that the diaphragm gets so tight that I really want them to get a lot of like lateral or like to the left and right of the body or towards

DR. HEATHER JEFFCOAT: the back. I want them to get more breath work through there to get more diaphragm expansion in the breath. And just sort of the feeling and the awareness of what is their pelvic floor doing with that breath work. So, and if I'm to the point where if it was appropriate to do an internal exam and I can assess what their pelvic floor is doing. doing during their breath work, normal pelvic floor muscle function would be that as you breathe, your lungs fill up with air and your diaphragm drops or lengthens, your pelvic floor should drop and lengthen with that. And as you exhale, your diaphragm is pushing the air out of your lungs. And so it kind of recoils and pushes upwards or lifts and

DR. HEATHER JEFFCOAT: the pelvic floor should rise with that. So I'm assessing also if there's a proper synergy between the diaphragm and the pelvic floor as well. And then also that their breath isn't causing any strain to the pelvic floor so that it should be, you know, they just have some awareness that there is a whole canister of movement. It's not just in one plane like in the abdominals and that they're as evenly as possible spreading that breath through that whole, you know, rib to pelvic floor section.

DR. ELLIOT BERLIN, DC: That makes sense. After birth, somebody realizes, hey, I think I have a separation. Are there specific things to not do? And also, I just think sometimes I see it, actually, people assume that because there's a separation, they have to start working their abs. And it seems like that can sometimes be counterproductive.

DR. HEATHER JEFFCOAT: So as far as things that you wouldn't do, I have patients avoid abdominal oblique exercises in the early phases, because that line of pull would be counterproductive to that narrowing that I'm trying to achieve as much as possible for the patient. Because for some, especially like my really thin patients, they don't like the cosmetics of a wider gap. Like you can see it even though it's not doming, it looks like it's caving in and it looks like a valley. So that's where I try to get that balance between good tension across the midline versus getting the gap closed. And so abdominal obliques would be counterproductive to that. It will not make it worse, but it certainly isn't going to do it any favors.

DR. HEATHER JEFFCOAT: And then in general, avoiding straining like any abdominal strain. So if you have constipation issues, if you're going back to lifting really heavy weights, you really have to make sure you have good pressure management and good awareness of maintaining that tension across the midline. So you don't prevent it from getting better. But like I said, I don't think those things postpartum are going to make it worse.

DR. ELLIOT BERLIN, DC: The question that I get frequently is, are the muscles ever going to get back to quote unquote, normal?

DR. HEATHER JEFFCOAT: Yeah. And I think that kind of goes back to what I said, it's that combination of like genetics and how much excessive strain you put through the abdominals. And you

know, your awareness and being able to maintain that tension across midline. So will it close all the way? Like, you know, possibly, you know, I think if I can get a patient to less than two of my fingers with they're doing pretty good. And that's usually not even cosmetically visible even on really thin patients. But you know, pre pregnancy, they're they were probably like one fingers width. So if they're using that as a normal, it's hard to say I haven't seen research that looks at that. But are you gonna get to a point where you're not going

DR. HEATHER JEFFCOAT: to notice it and it's going to support you adequately, and it's going to be activating properly so that it helps fight against pelvic floor dysfunction, like prolapse and incontinence and protects your back during the functional movements? Like, absolutely. Like that's possible for most women, like I said, unless they have some like deep fascial tearing where there's just no more connection across the midline.

DR. ELLIOT BERLIN, DC: If you don't treat it, does another pregnancy make it worse?

DR. HEATHER JEFFCOAT: Subsequent pregnancies, that is a really excellent question. And I have not seen any research on subsequent pregnancies. You know, I just think every pregnancy is different. So I mean, I've had women even thinking about like more with pelvic floor dysfunction, sometimes they have incontinence, they treat it, and then they have their second baby and they don't have incontinence again. And I think part of it's because they've addressed some of those issues as far as pressure management, especially or lack of coordination of the muscles. But with diastasis, you know, I think if you don't treat it, and it's not resolving on its own, another pregnancy isn't going to fix it. That's for sure. Whether or not it will make it worse. You know, I'd

DR. HEATHER JEFFCOAT: love to see some research on that. Yeah.

DR. ELLIOT BERLIN, DC: Okay, finally, if all these natural things, exercises, and other things don't do the trick, you mentioned surgery, what kind of surgery is it?

DR. HEATHER JEFFCOAT: I mean, that's a tummy tuck. So they're suturing the six pack back together at midline.

DR. ELLIOT BERLIN, DC: Literally sewing it back together.

DR. HEATHER JEFFCOAT: Exactly, which is providing cosmetic function, but it's not restoring muscle function. So although for some people, I would argue to say actually, because I've had some patients with very large diastasis fully split through midline, they can't generate any tension that is going to lead to back pain. I mean, they're coming to me because they have back pain, they didn't even know they had a diastasis and I can fit my whole hand. between their abs. And, you know, I really feel that's not cosmetic. I mean, they have full tearing and no ability to support their lumbar spine. And that should absolutely, in my opinion, be something that insurance should cover. But because it's a quote unquote tummy tuck, it's

DR. HEATHER JEFFCOAT: considered plastic surgery. So I don't know if that's ever going to change. But

DR. ELLIOT BERLIN, DC: well, I certainly learned a lot. And thank you for sharing all that information from your expertise with our audience. Heather, where could we find you online?

DR. HEATHER JEFFCOAT: So I am at FeminaPT.com. And I am very active on Instagram at TheLadyPartsPT as well as at FeminaPT. And we have four locations across Los Angeles. I am in Sherman Oaks, Glendale, Mid-Wilshire, and Claremont.

DR. ELLIOT BERLIN, DC: Thank you so much. I definitely would love to have you back if you're open to it, because there's so many other topics. You brushed across a few of them, but they're topics that people really struggle with. And the way you compile the information and deliver it is really digestible. Thanks again. Oh, thank you so much. Nice speaking with you. Thank you. And at home, thanks for listening to the Informed Pregnancy podcast. If you like the program, share us with your friends, leave us some feedback in your podcast app. And for more pregnancy and parenting-related media, visit us on Instagram at drberlin, D-O-C-T-O-R-B-E-R-L-I-N.

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